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FOCUS OF TRAINING IN CHILD PSYCHIATRY--THE INDIVIDUAL, THE FAMILY, AND THE COMMUNITY.

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THIS TRAINING PROGRAM FOR CHILD PSYCHIATRISTS DEPARTS FROM TRADITIONAL APPROACHES BY EMPHASIZING THE USE OF ALLIED MENTAL HEALTH DISCIPLINES, EXPERIENCE WITH FAMILY CHILD RELATIONSHIPS, AND A THOROUGH FOUNDATION IN NORMAL CHILD DEVELOPMENT. RESIDENTS BEGIN BY OBSERVING CHILDREN IN NURSERY SCHOOLS, DAY CAMPS, HOSPITAL NURSERIES, PEDIATRIC WARDS, AND A CAMP FOR ORGANICALLY-DAMAGED AND EGO-DISTURBED CHILDREN. INTENSIVE INDIVIDUAL DIAGNOSTIC STUDY IS MADE OF A VARIETY OF CHILDREN. SUCH DIAGNOSIS IS SIMPLIFIED BY CLASSIFICATION OF THE CHILD IN ONE OF FOUR MAJOR CATEGORIES. THE MAJOR FEARS OF THE CHILD AND THE CHILD'S SYMPTOMATOLOGY IN RELATION TO DEVELOPMENTAL AGE ARE STUDIED. THE RESIDENT LEARNS HOW TO USE THE SERVICES OF OTHER PROFESSIONS. HIS ROLE IN COMMUNITY AGENCIES IS CLARIFIED. HE LEARNS TO CONSTRUCT A PROGRAM FOR THE SPECIALIZED EDUCATION, SUPPORT, AND TRAINING OF CHILDREN WITH EGO DEFECTS. TRAINING IN INTENSIVE PSYCHOTHERAPY OF NEUROSES, CHARACTER NEUROSES, AND DISTURBANCES IN EGO FUNCTION IS SUPERVISED BY FOUR CHILD PSYCHIATRISTS. PREVENTATIVE WORK IN PUBLIC SCHOOLS, WITH THE MENTALLY RETARDED, AND WITH JUVENILE DELINQUENTS IS ALSO PART OF THE PROGRAM. THIS PAPER WAS PRESENTED AT THE 44TH ANNUAL MEETING OF THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, INC., WASHINGTON, D.C., MARCH 22, 1967. (PS)

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"Focus of Training in Child Psychiatry- The Individual, the Family, and the Community"

Harold Kolansky, M. D. and William Stennis, M. D.

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FOCUS OF TRAINING IN CHILD PSYCHIATRY - THE INDIVIDUAL, THE FAMILY, AND THE COMMUNITY

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Training in child psychiatry in this country largely began in the third decade of this century in community based clinics, established by courts and other community agencies to meet the enlightened awareness of the problems of children. Knowledge of children was limited at that time and medicine sought help from the behavioral disciplines of psychology and social work. Through such organizations as our own American Orthopsychiatric Association, the Commonwealth Fund, and the American Association of Psychiatric Clinics for Children, standards for training in child psychiatry were gradually established. The majority of these clinics were community agencies, in which there was enormous pressure to help as many children as possible. At the outset, the physician in such a clinic often began his training with a major disadvantage; he began to study psychopathology before he had a firm grasp of normal development. Also, for many years, medicine in general, and psychiatry in particular, failed to recognize child psychiatry as a separate specialty with its own training and certification requirements. Only as recently as 1959 was a specialty board established in this field. The establishment of this board, however, brought with it a major impetus toward upgrading training standards, and in the Spring of 1966, the Committee on Certification in Child Psychiatry,

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of the American Board of Psychiatry and Neurology, gave recognition to the progressive development of the child psychiatrist by permitting a resident to start his psychiatric training in child psychiatry rather than adult psychiatry. This allowed further refinement of the study of the individual child.

At the Albert Einstein Medical Center in Philadelphia, there had been an active department of Child Psychiatry solidly based in medicine and psychoanalysis for a number of years. In 1963 the Medical Center decided to establish a full-time teaching department of child psychiatry. At that time the authors designed a totally new two-year program which was quickly approved for full training in child psychiatry by the American Board of Psychiatry and Neurology. In its design we decided that each trainee must have a thorough foundation in normal development. We knew that due to a shortage of child psychiatrists as teachers, and for other reasons, many of the country's medical schools had not provided adequate courses in personality development, necessitating an emphasis on normal development, at the outset of our residency.

We felt that the traditional child guidance approach in which the child is seen by a trainee, and the parent is seen by a social worker, had certain disadvantages. From the standpoint of training, it deprived the residents of an opportunity to personally observe and learn about family interaction, and to properly develop skills in history taking in addition to assessing the child and working with him.

We also believe that the traditional approach did not make proper use of the allied mental health disciplines. The social worker had many

skills to offer in working with some parents whose children did not need to be seen directly in a therapeutic way. Thus in the large numbers of children needing special educational and family support, due to ego deficits, the social worker could frequently act as an effective bridge between child psychiatrists and parent or school, once a diagnosis was established and a therapeutic plan constructed. The psychologist also had major skills to offer beyond his ability to test children. Thus, he could be used as a key professional when disturbances in learning processes were evident. Using the psychologist selectively for testing, and in some therapeutic programs, also freed some of his time for much needed research and teaching.

We were convinced that a true understanding of a unit of society, such as the community or the family, was inadequate without a thorough knowledge of individual personality development. Moreover, it was evident to us that in the two-year training period we could not expose our trainees to every method of treatment. Therefore, we decided to focus on training him to be an expert on the individual child's development, problems, and treatment, while also exposing him to work with community agencies. In his training to be a consultant to these agencies, we did not emphasize his skills as an individual therapist, but rather as helping community agencies to incorporate varied principles of preventive medicine into their programs.

Thus the child psychiatry residency places early and continuing emphasis on the study of the individual child, his development (including the neurological substrata), his intrapsychic conflicts, the results of his problems on the family, and the interactions between the child and

the family as a consequence of his problems. At first glance, it would appear that this emphasis is no different from that in many residencies. However, we note with concern, the growing tendency to dilute such an approach to the study of the individual child in certain other training centers. As a consequence recommendations for treatment often lack specificity in such centers. Rather than treating the child's needs, there is an emphasis on family, social, and community psychiatry. At times a diagnosis is not even established, before embarking on such courses of treatment. Under the aegis of providing broader community service, there is the danger that the individual child and his problems can be lost. We are convinced that the community is best served through an individualized study of children, and that in actuality, recommendations can be carried out in an individualized way on many children using such an approach. We will outline what we mean.

The teaching efforts in the residency are based on a psychoanalytic model of the normal stages and lines of development and of psychopathology. This is coupled with training in the fundamentals of recognizing the growth and disturbances of the neurological apparatus. The residency program begins with the premise that emotional disturbances of children are incomprehensible without thorough knowledge of the normal development of the child. Normal development is best learned through direct observations of children of all ages and stages of development, and through seminars on these observations. Neither diagnosis nor treatment is possible without this kind of understanding.

Training in normal development is based on a series of direct observations and didactic lectures, seminars, and conferences related to

the meaning of these observations and compared with specific pathological entities.

Thus, the trainee starts his residency with direct observation of children in nursery schools, a normal summer day camp, the hospital nurseries and the pediatric wards on three half days each week. Instructors accompany the trainees, direct their observations, and discuss the meaning of the observations with them. At first we teach the residents how to observe and what to look for, by discussion and demonstration. In this formative period, the resident also spends one day weekly at a camp for organically damaged, and ego-disturbed children, for the purpose of highlighting the vast differences in clinical appearance of the normal child, and the very disturbed child. We have found that such an introduction teaches the resident the fundamentals of diagnosis most quickly. In the observations done at the camp for disturbed children, the resident begins to learn to look for gross psychological signs of distress. Through instruction in neurological examination, with a concentration on the so-called "subtle" signs, the resident learns to recognize minimal brain dysfunction. Motion picture and still photography of normal and disturbed children supplements this phase of training. During this introductory period, the resident also has conferences on history taking and the examination of the child, in addition to lectures and conferences on the diagnostic entities. A choice of cases for treatment in the child psychiatry out-patient clinic is generally made by the second month of the residency.

Following such an introduction, the residents feel more secure in recognizing psychopathology and mild to severe neurological problems of psychiatrically ill children. While developing psychological skills, in-

struction in neurology and the opportunity to see large numbers of children on the pediatric pavilion, tend to help the resident retain his identification as a physician. Simultaneously, this training aids the resident in gradually assuming the full and traditional role, trust, and responsibility of the physician, in the study and treatment of the individual who is ill.

During the course of the residents' further training, continuing emphasis is placed on intensive individual diagnostic study of a wide variety of children to enable the resident to make appropriate descriptive, dynamic, and developmental diagnoses. These diagnoses entail a thorough knowledge of the child and his development, conflicts, and interactions. To simplify diagnosis, we classify each child in one of four major categories: (a) Normal Development, (b) The Psychoneuroses and Character Neuroses, (c) Disturbances in the Ego, and (d) Preoedipal Fixations or Developmental Arrests. In the category of normal development, we include age appropriate manifestations, which may at other ages look abnormal. Thus, mild animal phobias, and nightmares in the phallic phase, or mild obsessional rituals in latency, would be examples of the numerous variants of normal development.

In classifying psychoneuroses, we include the acute and chronic states of anxiety, phobias, conversion reactions, regressive and fixed types of obsessional disorders, and also the character neuroses. When we speak of disturbances in the ego, we refer to disorders which interfere significantly with one or more functions of the ego. Thus the ego disturbances as described by Weil, and all forms of psychoses would be included. Also, since the major psychopathology in organic syndromes involving the central nervous system, is basically due to disturbances in

various ego functions such as the control of motility, we include such disorders in this category, as we also do with mental retardation which invariably affects the testing of reality, intellectual function, object relations, and control of motility. In grouping these various entities as ego disturbances, we are able to look more intently for specific malfunctions in the ego of each child in this category, and further, can search for organic pathology (including that related to subtle neurological signs) in many of these entities.

In the final category of preoedipal fixations, we classify those disorders which are due to lack of forward movement in ego, or drives, rather than due to internal psychic conflict as in the neuroses, or due to specific ego psychopathology (and often organicity) as in the disturbances in the ego. These disorders include the child who is continuously enuretic or encopretic, and also the child who is only interested in immediate gratification of other needs, and who has extremely low frustration tolerance.

There are, of course, a number of conditions, which others classify separately, but which lend themselves to classification under one of the four categories, when the major dynamics are known. Thus delinquency may be due in one instance to an organic mental syndrome, or in another be related to and classified as a manifestation of neurosis when the need for punishment is predominant. Similarly a depression may be due to severe object deprivation, and then be related to an ego disturbance, or may instead be primarily due to neurotic conflict. Psychosomatic disorders can also be primarily related to one or another of these categories. Similarly, a learning disturbance may be primarily classified as a pregenital fixation, if based on the intolerance for delay in gratification,

while if due to conflict it is classified as psychoneurosis. Other learning disturbances are of course due primarily to an ego disturbance and can be seen in the various psychoses, retardation, and organic mental syndromes.

Dynamically, we consider the child's major fears as (a) fear of loss of the love object, (b) fear of loss of the object's love, (c) fear of castration, and (d) fear of the superego. Developmentally, we consider the child's symptomatology in relation to developmental age, and to factors in the history and the clinical interviews which indicate fixation, or regression in relation to developmental age. The resident may call upon the service of other professionals, including the psychologist, child psychiatric social worker, the educational psychologist, neurologist, and educator, as indicated. In that sense, the resident's training includes portions of the traditional child psychiatry team approach, but unlike such a traditional approach, the resident gradually becomes responsible for his own personal study of the case under supervision by the faculty, and his personal selection of the other professionals who may aid that study. Thus, he finds that his diagnosis is aided by psychological testing of children having ego disturbances with questionable signs of organicity, and for children with learning problems. He soon learns, however, that it is wasteful of the valuable time at the disposal of the psychologist, if the resident called upon the psychologist to test every child with a neurosis. Moreover, he finds that collaboration with a social worker is useful when additional psychopathology in other children in the family is found. Through such detailed diagnostic studies, the resident gradually develops a comprehensive picture of the child and can make appropriate recommendations to the family for treatment.

If the preponderance of evidence gathered through this study shows intrapsychic conflict, he knows that he is dealing with a psychoneurosis and that the optimal treatment would be either child psychoanalysis or intensive psychotherapy. Meanwhile through his careful assessment of development and psychodynamics, he has a fairly good idea of the specific areas contributing to the difficulties. If his time permits, he begins psychotherapy while simultaneously seeing the parents in supportive and continuing fact-gathering contacts, or he may collaboratively work with the social worker in some instances in which it would be to the child's advantage for the resident not to see the parents. In the latter instance, the social worker sees the parents and has continuing contact with the resident keeping the focus on understanding and treating the child. In treating children with neuroses, the resident also learns that at times the parent needs individual psychotherapy, since in some instances neurotic interaction within a family is disrupted by improvements in the child, causing the parent to experience more acute anxiety. When the latter occurs, the resident is taught that a tactful and slowly-paced recommendation for individual psychotherapy with another psychiatrist, is often accepted by the distressed parent. When that situation occurs, the parents' contacts with the resident or social worker continue so that the focus on the treatment of the child is never lost.

For most non-neurotic children recommendations are for treatment methods other than individual psychotherapy. Thus with children who have very severe impairment of specific ego functions (as in psychoses, organic syndromes, and mental retardation), the resident develops skill as a consultant to the social worker, psychologist, teacher, school

counselor, and tutor. He slowly learns to construct an individual "prescription" for the specialized education, support and training of these children, and their special ego defects. In relation to this large latter group, the resident's experiences equip him for a major aspect of what we feel to be the community role of the child psychiatrist. Here, the emphasis is again on the individual child rather than to use an often ineffectual and sometimes damaging group or family therapy involving the child and other family members simultaneously. In such an approach, the resident can actually direct and manage the treatment of a very large number of children in the community.

The core of the resident's direct treatment experiences with children, therefore, centers around the carefully supervised intensive psychotherapy of the neuroses, character neuroses and mild to moderate disturbances in ego function. In this work the resident is supervised by four child psychiatrists who are certified in the specialty, and are trained in child analysis. His four supervisors continue to work with him weekly throughout the two years of the residency. The resident also gains experience in brief psychotherapy and preventive child psychiatry, while working with a great many children who are hospitalized for pediatric medical and surgical reasons. The latter work is also directly supervised by a child psychiatrist on the pediatric pavilion.

Although the bulk of the training experiences occurs at the Albert Einstein Medical Center, about one-quarter of the resident's time is spent in affiliated institutions, including our own unit for psychotic children in a large children's psychiatric hospital, and in consultative experience in a large public school system.

We feel that much preventive work can be fostered in public schools, and of course this adds another, and extremely large aspect to experiences in community psychiatry. Each resident spends one day a week for a three-month period of time with his child psychiatry supervisor in a public school system. The resident observes the work of this consultant to the school system, and becomes aware of how developmental history, parental personalities, school practices, psychological testing, psychiatric and neurological examinations all provide data for the writing of an individual "prescription" for a child in a classroom. He learns how this focus on the individual child is utilized to educate the child's teacher, guidance counselor, and principal on the problems of all children.

Work with children and personnel in one of the country's oldest schools for the mentally retarded is also provided, as is experience with the juvenile aid officers of a metropolitan police force, who work with individual delinquents through a gang control unit of the police department. For the latter training experience the residents ride in the gang control officers' police cars during their evening rounds, following which the residents and their faculty instructors, who accompany them, meet the police officers to discuss the delinquent youngsters seen and interviewed during the course of the evening.

Supervisors of trainees in affiliated institutions hold dual appointments at the Center and at the affiliated institution coordinating the training. This allows the resident to continue his training in a guided, progressive, systematic fashion. In the affiliated institution skills pertaining to consultative practice, preventive work within a school system, and the use of the many educational modalities available today for aiding

specific development or impaired ego functions are utilized.

Throughout the two-year-period, the residents continue to attend weekly diagnostic conferences, and also weekly lectures by the Center's staff, and visiting experts who present the descriptive, dynamic, and diagnostic entities within a framework of development. For example, while studying the development of the latency age child, the lectures on psychopathology center around typical latency age problems, such as the obsessive compulsive neuroses, and related character disturbances. While studying the development in the phallic phase, the resident hears lectures and discussions on the phobias, anxiety states, pavor nocturnis, and hysterical states, all of which are seen as part of the infantile neuroses of the phallic-oedipal phase of development. Additionally, the resident attends a weekly pediatric child psychiatry conference, at which time cases are presented from the pediatric pavilion with special emphasis on management of the child who is anxious about his hospitalization. Throughout the year the resident attends weekly seminars on a psychoanalytic understanding of child development and on the literature of child psychiatry and child psychology. The literature seminars are closely related to the lectures and observations of development with coordination of psychopathology in specific phases of development. In the psychology seminars, testing is presented developmentally with constant correlation of clinical and psychological data in a psychoanalytic framework, and also in relation to learning theory, and the work of Piaget.

The approach to understanding the individual child through an emphasis on his development and emotional problems is also used in the teaching of pediatric interns and residents. General psychiatry residents

from the Albert Einstein Medical Center and other institutions spend about one-quarter of their time in child psychiatry at the Albert Einstein Medical Center, and their training is similar, although abbreviated. Medical students from several medical schools also come to the Albert Einstein Medical Center for six and eight week clerkships in child psychiatry, during which time the emphasis is on utilizing progressive knowledge of development, in a preventive way, with the individual child.

Although a personal psychoanalysis is not a requisite to the residency, such an analysis is strongly recommended to the resident during the course of his training, and many of our residents do have analysis. Through self-understanding, the resident has less difficulty understanding and empathizing with children, and does not tend to make use of treatment methods which obscure the unconscious components in illness, and the ego defenses utilized by child and family.

Even before analysis, we find that the intensive study of the individual child increases the resident's understanding of children, and of his own childhood as well. Occasionally, a resident, medical student or intern becomes very apprehensive in his exposure to the child's unconscious derivatives and tends to defend himself by denying the importance of the unconscious in the evolution of the human personality. In our setting, however, this denial cannot long continue since the clinical data, consistently demonstrates the importance and validity of psychoanalytic theory. Socrates' statement that a life unexamined is not worth living, becomes alive, meaningful, and exciting to the resident.

In addition to a body of knowledge, we attempt to include in this residency, a method for the lifelong process of gathering data about the human child, and the vicissitudes of his development.